NEW JERSEY

CHILD FATALITY AND NEAR FATALITY REVIEW BOARD - CITIZEN REVIEW PANEL

2001 – 2002

ANNUAL REPORT

New Jersey Child Fatality and Near Fatality Review Board
and
Citizen Review Panel
(2001-2002)

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Introduction

This is the third annual report of the Child Fatality and Near Fatality Review Board and Citizen Review Panel (henceforth referred to as the CFNFRB). The report includes an overview of the activities and issues raised by the CFNFRB in the past year, as well as any actions that may have been taken to address them. During the past year, the CFNFRB has also undertaken a review of the New Jersey CCAPTA statute as it relates to the CFNFRB's scope of responsibility and its current functioning in conjunction with the administration of the New Jersey Department of Human Services (DHS), Division of Youth and Family Services (DYFS).

In August 1990, the Commissioner of the New Jersey Department of Human Services established the Child Death and Critical Incident Review Board by Administrative Order. In January 1991, the Child Death and Critical Incident Review Board began reviewing child fatalities. In December 1992, the status of the Board's authority was changed from a Departmental Administrative Order to State regulations that have the force and effect of law.

The Child Death and Critical Incident Review Board was mandated to review child deaths due to child abuse or neglect in which the family was currently or previously, within 12 months of the incident, receiving services from the Division of Youth and Family Services. The Child Death and Critical Incident Review Board concluded its life in 1998 with the review of 1997 child deaths and critical incidents. The adoption of N.J.S.A. 9:6-8.88, the New Jersey Comprehensive Child Abuse Prevention and Treatment Act (CCAPTA), on July 31, 1997, created the Child Fatality and Near Fatality Review Board which replaced the Child Death and Critical Incident Review Board. The Governor officially appointed the members of the CFNFRB in May 1998.

Although the CFNFRB is placed administratively in the Department of Human Services, it is statutorily independent of "any supervision or control by the department" or any of the Department's other "boards or officers."

The scope of incidents that are subject to review has changed to include child fatalities and near fatalities in the State of New Jersey as specified in N.J.S.A. 9:6-8.90. The CFNFRB continues to meet monthly to fulfill this mandate. The principal objective of the CFNFRB is to provide an impartial review of individual case circumstances and to develop recommendations for broad-based systemic, policy, and legislative revisions and innovations for the purpose of preventing future child fatalities. According to CCAPTA, the purpose of the CFNFRB includes, but is not limited to, the following:

- To review child fatalities and near fatalities in New Jersey in order to identify the cause of the incident, the relationship of the incident to governmental support systems, as determined relevant by the CFNFRB, and methods of prevention;

- To describe trends and patterns of child fatalities and near fatalities in New Jersey, based upon its case reviews and findings;

- To evaluate the response of government support systems to the children and families who are reviewed and to offer recommendations for systemic improvements, especially those that are related to future prevention strategies;

- To identify groups at high risk for child abuse and neglect or child fatality, in terms that support the development of responsive public policy; and

- To improve data collection sources by developing protocols for autopsies, death investigations, and the complete recording of the cause of death on the death certificate, and make recommendations for system-wide improvements in data collection for the purpose of improved evaluation, potential research, and general accuracy of the archive.

Pursuant to N.J.S.A. 9:6-8.90, the CFNFRB's mandate also requires identification of fatalities in which the cause of death is, or may have been, due to any of the following conditions or circumstances:

- The cause of death is undetermined;
- Death where substance abuse may have been a contributing factor;
- Homicide, child abuse or neglect;
- Death where child abuse or neglect may have been a contributing factor;
- Malnutrition, dehydration, or medical neglect or failure to thrive;
- Sexual abuse;
- Head trauma, fractures, or blunt force trauma without obvious innocent reason, such as auto accidents;
- Suffocation or asphyxia;
- Burns without obvious innocent reason, such as auto accident or house fire; and
- Suicide.

In addition, CCAPTA mandates the CFNFRB to identify children whose family was under DYFS supervision at the time of the fatal incident or near fatality or who had been under supervision within 12 months immediately preceding the fatal incident or near fatality. The CFNFRB also examines and identifies approaches to achieve better coordination of effort regarding child welfare and child protective services cases to promote prevention and the competency of response and investigation of reports of maltreatment.

The CFNFRB is empowered to select cases from among these categories and to conduct a full review.

Finally, CCAPTA requires the CFNFRB to establish regulations to govern its activities. CCAPTA stipulates that the CFNFRB submit an annual report to the Governor and State legislature, and that the report be made available to the public. The CFNFRB is required to report as follows:

- Trends among unusual fatalities and near fatalities;
- The number of cases reviewed and specific non-identifying information regarding cases of particular significance;
- Risk factors and the governmental support systems available and responsible for support; and
- Recommendations for improving sources of data collection, achieving better coordination and collaboration among State and local agencies, and recommendations for system-wide improvements in services to prevent child fatalities and near fatalities.

Near Fatalities

Although near fatalities are also subject to review, the CFNFRB continues to work to develop a protocol for identifying near fatalities, developing strategies for data collection, and selecting strategies for review.

The Federal Child Abuse Prevention and Treatment Act (CAPTA) requires each state receiving a Federal grant under 42 U.S.C. 5106a to establish no less than three citizen review panels. As specified in the introduction, the citizen review panels were established to examine and evaluate the child protective services delivery system in the state. In accordance with Federal CAPTA requirements, the Commissioner of the Department of Human Services selected the CFNFRB to sponsor and develop one of the three panels. The newly created CFNFRB elected to function as a panel itself, rather than to develop an auxiliary body. Thus, it performs a dual function. The activities of the CFNFRB meet the citizen review panel requirements. Therefore, separate meetings are not required to fulfill this additional responsibility. Likewise, the annual report of the CFNFRB also serves as its citizen review panel report.

Organizational Issues

In 2001-2002, the CFNFRB continued to refine its organizational structure. In particular, it has continued to focus on the development of its four Regional Child Fatality and Near Fatality Community-Based Review Teams (henceforth referred to as Teams). The CFNFRB also continued to face substantial challenges in setting operational priorities due to case backlog, developing a review protocol for continuity across statewide and regional reviews, and categorization of cases for review to identify cases in need of full review in light of evolving statutory requirements.

Regional Child Fatality and Near Fatality Community-Based Review Teams

In the past year, the CFNFRB concentrated on continuing to support and develop its four teams. The CFNFRB addressed ways to improve communication between the teams and the CFNFRB. In particular, feedback to governmental departments and health care providers from the teams to the CFNFRB was structured so that the CFNFRB reviewed all recommendations and correspondence. Team membership, diversity and attendance were reviewed. As noted in last year's report, a central and guiding principle of the CFNFRB's establishment of local teams, as permitted in N.J.S.A. 9:6-8.91(a), was to enable local communities to learn from each child fatality and to assume ownership of developing prevention initiatives and strategies at the local and regional level.

The teams continue to review cases that were either formerly known to DYFS or are unknown to DYFS. A major concern raised by the Team Chairpersons was their ability to manage the volume of fatalities in the State. The CFNFRB continues to review fatalities and near fatalities under active DYFS supervision. The CFNFRB established the following review priorities for the four teams:

- Deaths due to maltreatment not under DYFS supervision;

- Suspicious deaths; and
- Sudden and unexplained deaths, including Sudden Infant Death Syndrome (SIDS).

Three DYFS staff members continue to support the activities of the CFNFRB and its teams. The CCAPTA Coordinator continues to maintain responsibility for the CFNFRB and the two additional support staff who have direct responsibility for two teams, each. Support staff continue to be responsible for obtaining the necessary documentation to conduct fatality and near fatality reviews, recording the activities of team meetings by taking minutes, providing an oral report to the CFNFRB on the progress of each team at CFNFRB meetings, and sharing information with the teams about the CFNFRB's meetings. Support staff reports to the CFNFRB include an overview of the cases the teams are reviewing, systemic problems they have identified, and the team recommendations or requests for assistance and follow-up. The teams also share each other's minutes.

The CFNFRB's 2000-2001 report noted that CCAPTA support staff conducted a survey of states in order to assist the panels and teams to identify the review processes and organizational protocols utilized by citizen review and child fatality review entities in other states. The CFNFRB identified that the State of Colorado appeared to have a well-developed process and decided to study the review protocols Colorado had established. The CFNFRB and Team Chairpersons were in agreement with expanding the New Jersey criteria to include the Colorado protocols as the teams were already conducting reviews in much the manner outlined by the Colorado protocols. In June 2001, the CFNFRB formerly added the Colorado protocols to the New Jersey criteria.

As a way to ensure continued communication among the teams, the CFNFRB Chairperson routinely held meetings with the Team Chairpersons. These meetings were useful in identifying cross cutting issues or difficulties encountered by a specific team. The CFNFRB also approved sharing the CFNFRB minutes with the teams to assist in the development of uniform review standards. As of January 2001, the CFNFRB began reviewing and ratifying the minutes of each team. The CFNFRB will begin to incorporate fully the recommendations of the teams in subsequent reports. The CFNFRB discussed ways to reassure and support the teams. The CFNFRB established liaisons to each team to address questions or concerns directly with the CFNFRB. Liaisons would attend team meetings on a quarterly basis and report back to the full CFNFRB.

A checklist for requesting information on cases by category was drafted. This record review form continues to be developed but not yet finalized by the CFNFRB. The checklist will hopefully help to address uniform review standards by the teams.

Various team members, including one Team Chairperson, resigned during this past year. The CFNFRB reviewed resumes and appointed individuals who had been recommended for team membership. This process prompted a discussion by the CFNFRB about the CCAPTA statute membership requirements for each team, as well as the ethnic diversity of each team. Staff support provided the CFNFRB with each team's membership by discipline and ethnic background. The CFNFRB's review of the membership roster of each team resulted in a request for appointment of regional law enforcement and prosecutor members to the teams. The CFNFRB sent a letter to each of the County Prosecutors that serve the geographic areas of the teams and requested they designate an alternate and designee in these areas. As a result, the teams have begun to see representation in these areas. The CFNFRB also found that three of the teams do not adequately mirror the ethnic composition of the area in which they operate and

requested that each Team Chairperson consider the ethnic composition within each team when making a recommendation to the CFNFRB for team member appointment.

Through updates by support staff, the CFNFRB learned that the teams were experiencing some problems with regular attendance. The CFNFRB, with the assistance of support staff, developed an attendance log for each team that demonstrated the attendance record of each team member. The CFNFRB forwarded the respective log to each Team Chairperson so that they could address the issue of attendance with their respective team.

The resignations and attendance issues also lead to the CFNFRB's re-evaluation of membership of the teams. The CFNFRB found that the teams had duplicate members who were either from the same discipline or specialties within a discipline. After some deliberation, the CFNFRB decided that membership required by the CCAPTA statute (prosecution, local law enforcement investigation, medical examiner, public health advocate, physician, and case work supervisor from a division field office) would be considered "core" members. However, the CFNFRB, recognizing the value of the contributions of other disciplines, decided that the remaining appointed members would be considered "consulting" members. Consulting members would not be required to attend team meetings unless a case involved an issue in the member's specialty or they were invited at the request of the Team Chairperson.

The CFNFRB addressed the teams' review of children who die outside of their county of residence or children from other states who die in New Jersey. The CFNFRB established that review of child fatalities by a team would be determined by where the fatality occurred. A team would decide, on a case-by-case basis, which regions would review multiple jurisdiction cases. The CFNFRB addressed major case concerns raised by the teams by approving and forwarding letters on their behalf. However, the CFNFRB had not developed a mechanism to discuss and/or ratify the minutes of each team. Because of this, the CFNFRB has not included fully the recommendations of its teams in the prior annual reports.

Statistical Reporting

The CFNFRB continues to rely on child fatality data generated by the Department of Health and Senior Services (DHSS), the Office of the State Medical Examiner (SME) and DYFS, to compile data on child fatalities. As with the previous report, the CFNFRB's compilation of data on child fatalities is reported subsequent to the DHSS and SME submissions. The Department of Health and Senior Services and the Office of the State Medical Examiner each experience lags of three to six months or longer, in reporting. These reporting delays impact on the CFNFRB's ability to publish final data for the previous calendar year by June 30. As a result, the CFNFRB elected to revise its means of reporting cumulative statistical data. The CFNFRB's deliberations resulted in the adoption of a "two-tiered" annual report. The CFNFRB elected to produce a "process" report, addressing activities, trends, themes, and issues that would be published by June 30 of each year. A supplemental statistical report for the previous calendar year will be published annually within six months from the time the CFNFRB receives final statistics from the DHSS and the SME.

On November 8, 2001, the CFNFRB established the Process Report/Statistical Data Subcommittee. The subcommittee was established to assist with the two-tiered reporting system that the CFNFRB had adopted. The responsibilities of the subcommittee include the

development of a report for June 30 each year and a subsequent statistical data report. On October 11, 2001, the CFNFRB also established the Regulations Subcommittee to review the New Jersey legislative mandate to assure that the CFNFRB's procedures and functioning are consistent with the law.

CFNFRB Subcommittees

The CFNFRB recognizes that its monthly meeting schedule does not afford it the opportunity to effectively address various administrative matters during regularly scheduled monthly meetings. To this end, the CFNFRB has addressed this concern by extending the hours of some of its monthly meetings, and has begun to explore the development of a computer on-line list serve. The CFNFRB has also established the following standing and/or ad hoc subcommittees:

- Process Report/Statistical Data Subcommittee
- Grants Subcommittee
- Regulations Subcommittee
- Orientation Handbook Subcommittee

The CFNFRB elected to address the following major areas of inquiry:

Training and Education

SIDS

CFNFRB membership consists of medical, legal, and other child protection experts. Nonetheless, the CFNFRB found that its review of Sudden Infant Death Syndrome (SIDS) fatalities often raised questions regarding programs or services. This lack of knowledge hampered the CFNFRB's ability to make recommendations in some instances. The CFNFRB concluded that it would be important to the growth and functioning of the CFNFRB to gather additional information related to the diagnosis of SIDS. The CFNFRB knew of two SIDS Centers in New Jersey and arranged for a presentation to learn more about the mission of the SIDS Centers and the programs/services they provide.

In December 2001, the CFNFRB arranged for a presentation by Mr. Robert Hinnen, Program Director, SIDS Center of New Jersey, Hackensack Medical Center. The other SIDS program is located at St. Peter's Hospital in New Brunswick. The CFNFRB was made aware that the SIDS Centers provide a 24-hour support hotline, maintain a data bank, provide bereavement counseling, refer individuals to support groups, and maintain involvement in statewide public health initiatives and educational community outreach programs. The main thrust of the SIDS Centers is the education of the community regarding SIDS. Training also is provided to hospital and law enforcement personnel. Mr. Hinnen provided a historical overview on the development of SIDS as a diagnosis and some data, based on a sociological profile. The CFNFRB also became aware that parents as well as the CFNFRB are able to request, through the SIDS Centers, at no cost, an opinion from a pediatric pathologist if they do not agree with the findings of a medical examiner. The CFNFRB learned that New Jersey has only two such pathologists. One is Dr**.** Frederick DiCarlo who is a member of the Central Team. The CFNFRB shared the information obtained with its four teams.

The CFNFRB continues to note inconsistent practices in autopsies completed by County Medical Examiner's (CME), relating to diagnosis in SIDS cases. In January 2002, the SME forwarded three separate letters addressing the concerns of the CFNFRB.

Safe Sleep Campaign

The CFNFRB and teams continue to note the deaths of infants who were sleeping with a caretaker when the fatality occurred. Many of these deaths appear to result from "roll-overs." The CFNFRB and teams expressed a need to educate the public regarding the danger of sleeping together with infants because of the danger posed by "roll-over" deaths. Several cases also involved the use of inappropriate bedding.

The New Jersey Task Force on Child Abuse and Neglect initiated a campaign to promote safe-sleep habits for parents and infants.

Division of Youth and Family Services

Information Needs

The CFNFRB has determined that the Division's Service Information System (SIS) is antiquated and does not provide the Division with the information it needs. As an example, high-risk cases have to be tracked individually by DYFS field offices because SIS does not have the capability to do so, statewide. Also, the SIS is only able to register families who are receiving services. In addition, field offices have to develop individual systems to track safety assessments, a component of the DYFS Structured Decision-making Model.

Case Presentation System

The mode of case presentation was changed in the past year. Staff of the DYFS Office of Program Operations outlined their concerns to the CFNFRB, as well as safety and risk issues related to child fatality. DYFS staff directly involved with the case provided information; clarification and insight into case dynamics to raise the level of casework by benefiting from interdisciplinary review. The expanded attendance has helped to create a link between caseworkers, supervisors, and administrators. The CFNFRB found the presentations on the circumstances surrounding the death generally comprehensive, succinct, and inclusive**.**

Decision Making

In cases reviewed by the CFNFRB in 2001-2002, the CFNFRB continued to find unevenness in DYFS case practices across the State. It should be noted that the fatalities in the cases under review occurred prior to some significant and positive changes in case practice standards. The Division remains open to external review and eager to receive feedback regarding case management. DYFS had established working committees to develop components of a Structured Decision-Making Model (SDM) that addresses key decision points for all children. To date, a process of assessing children's safety has been implemented across the state. The CFNFRB received updates from the Division on its implementation of SDM. The Division has trained staff and implemented a safety assessment process in each of its district offices. The Division plans to

implement safety assessment in other appropriate organizational units, as well. The Division is also working on the development of a risk assessment tool and revised screening protocols.

Medical Examiner System

The Office of the State Medical Examiner continues to serve primarily in an advisory capacity to the county-based system and to have limited influence on compliance with practice standards at the local level. The CFNFRB continues to find that the county-based system is fragmented and functions at varying levels of efficiency and responsiveness. The county-based system continues to experience reporting delays and the inconsistent application of established protocols. The CFNFRB recommended the development of legislation to specify that the Office of the Medical Examiner should function as the overseer of a unified statewide system. The CFNFRB believes the change is needed to assure the medical examiner system functions consistently across the State. The CFNFRB also believes that reasonable standardization is critical to the CFNFRB's ability to review fatalities accurately and comprehensively.

In 2001-2002, the SME submitted plans to the Division of Criminal Justice (DCJ) for the establishment of a statewide medical examiner structure on a regional basis. Recognizing the delays inherent in revising state statute, N.J.S.A. 52:17B-78 et seq. (State Medical Examiner Act), and as an immediate measure, the SME suggested through the DCJ that an Executive Order be sought from the Governor to give the SME additional powers over County Medical Examiner (CME) offices and their resources to effect such change.

Forensic Medical Issues

Histological Eye Examination

In 2000-2001, the CFNFRB noted that reports from CME's sometimes lacked the detail needed to make an accurate assessment of the fatality. The CFNFRB specifically identified that CME's did not, as a standard practice, remove and examine the eyes in suspected child abuse cases. The CFNFRB recommended that a histological eye examination, after enucleation, be performed in the following cases, especially if there is no documented clinical fundoscopic examination:

- Child abuse under the age of three years;
- Suspected child abuse under the age of three years;
- Shaken baby syndrome;
- All head injuries under the age of three years; and
- All unexplained deaths under the age of three years, if there is cerebral edema.

In the past year, criteria has been established and implemented through the SME based on the recommendations of the Sudden Child Death Autopsy Protocol Committee and the International Protocol for SIDS for histological eye examinations in designated child fatalities. CFNFRB members also met with the Attorney General to discuss addressing this issue with the CMEs. This resulted in the Attorney General forwarding a letter to all CMEs, urging their cooperation with the recommendation on histological eye examinations by the SME and the CFNFRB.

Skeletal Surveys

The CFNFRB continues to address concerns regarding radiological evaluations utilizing the "babygram," in lieu of a skeletal survey in suspected cases of abuse. It also continues to find x-ray evaluation reports that do not meet the American College of Radiology (ACR) standards. The CFNFRB previously wrote to the chairperson of the radiology department of each hospital advising of the standard and asking that the chair review these recommendations with the radiological staff, technician staff, and emergency department staff. The CFNFRB included a copy of the standards obtained from the American College of Radiology with the communiqué. The CFNFRB also forwarded this information to each county medical examiner for their use in forensic examinations.

In 2001-2002, CFNFRB members met with the Attorney General to discuss how to address this issue. This meeting resulted in the Attorney General forwarding a letter to all CMEs urging their cooperation with the recommendation by the SME and the CFNFRB. The CFNFRB plans to contact the DHSS to obtain a recommendation on how to implement the ACR standards in x-ray evaluations by other medical professionals. However, the CFNFRB continues to find that all hospitals and CMEs do not uniformly follow the standards.

Department of Health and Senior Services

Database

In last years' report, the CFNFRB noted the fragmented way in which child fatalities are reviewed and how data is collected. There are numerous entities that become involved in parallel review of child fatalities. These entities include, but are not limited to, the New Jersey SIDS Center, Fetal Infant Mortality Review, internal hospital morbidity reviews, and the Child Fatality and Near Fatality Review Board. Additionally, the Department of Health and Senior Services collects death certificate data and the Office of the State Medical Examiner collects autopsy data. In January 2001, the CFNFRB provided a letter of support to the Department of Health and Senior Services which, in collaboration with DYFS, applied for a Federal "State Mortality/Morbidity Review Support Program" grant. The project proposes to coordinate the Fetal-Infant, Maternal-Mortality and Child Fatality and Near Fatality Review systems and to develop a case identification system that allows for accurate, comprehensive, and timely identification and notification of deaths. The project also proposes to develop a shared data system. In May 2001, the Department of Health and Senior Services was awarded the grant. The CFNFRB recommended that the Department of Health and Senior Services develop a database that can be utilized by the various agencies involved in child fatality and mortality reviews. The database should also include law enforcement reports, medical records, and other information relevant to the psychosocial context of the death.

In 2001-2002, the DHSS established a Mortality/Morbidity Advisory Group (including CFNFRB membership) consisting of agency representatives involved in mortality/morbidity reviews, put forth efforts to hire a data specialist, and developed plans to sponsor a “Mortality/Morbidity Review Summit” in October 2002. The goal of the summit will be to provide an overview of the Mortality/Morbidity Review Project and of each existing mortality/morbidity review entity.

Progress on 2000 - 2001 Recommendations and Goals

- The CFNFRB decided it would produce a "process" report by June 30 each year and a supplemental statistical report within six months from the time the CFNFRB receives the final lists of fatalities from the State Medical Examiner and the Department of Health and Senior Services. In an attempt to meet CCAPTA requirements, the CFNFRB is in the process of reviewing the New Jersey legislative mandate to assure that the CFNFRB's procedures and functioning are consistent with the law.

- The CFNFRB continued to recommend that DYFS identify case practice and decision-making standards that are applied consistently and equitably across the State. It supported DYFS' development of a Structured Decision-Making Model to achieve this goal. The CFNFRB has received updates from the Division on the development and implementation of SDM.

NEW JERSEY

CENTRAL REGIONAL

CHILD FATALITY AND NEAR FATALITY

COMMUNITY-BASED

REVIEW TEAM

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(2001-2002)

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NEW JERSEY

METROPOLITAN REGIONAL

CHILD FATALITY AND NEAR FATALITY

COMMUNITY-BASED

REVIEW TEAM

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(2001-2002)

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NEW JERSEY

NORTHERN REGIONAL

CHILD FATALITY AND NEAR FATALITY

COMMUNITY-BASED

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(2001-2002)

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NEW JERSEY

SOUTHERN REGIONAL

CHILD FATALITY AND NEAR FATALITY

COMMUNITY-BASED

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(2001-2002)

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